POINTS IN OFFICE PRACTICE

IN THE

TREATMENT OF THE DISEASES OF WOMEN.

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POINTS IN OFFICE PRACTICE IN THE TREATMENT OF THE DISEASES OF WOMEN.

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The limitations of office practice, in the treatment of the diseases of women, what should be attempted and what should be avoided, forms a subject of very practical importance to every one engaged in this department of therapeutics.

I wish first to bring to your attention certain procedures which I believe should be avoided.

Under the old *régime*, before the days of anæsthetics, and before the dawn of the antiseptic era, it was a somewhat necessary custom for the surgeon to minimize the gravity of operations, and to conceal the paraphernalia in order to avoid the mental effect on the patient which otherwise would be produced. This, however, is no longer the case. In those days, also, the nature of the causes of the inflammatory processes which may follow operations were not understood, hence the necessity for careful preparation of the field of operation was not appreciated. As a result of these conditions disastrous consequences, due usually to sepsis, not infrequently followed apparently trifling operations. These facts cannot be borne in mind too strictly, nor can apparently trifling operations, done in the office without attention to every requirement of antiseptic surgery, be too carefully avoided. To twist off a polyp, to dilate the cervix, or to curette the uterus appears like a trifling operation, but if done without careful disinfection of the field of operation, and of the hands and instruments of the surgeon, serious inflammation of the pelvic tissues, and even death may result. It is not an uncommon practice for men to dilate the cervix "just a little" in the office, and to repeat the process from week to week, for the relief of dysmenorrhœa. This is called the gradual method of dilating the cervix. Some years ago I

saw this done many times, and the consequences were what should have been foreseen—in a definite number of cases—infection with permanent crippling of the uterine appendages resulted. In the same way I have seen the dull curette used on the ground that its use is a trifling matter and that it can do no harm. I feel certain that such practice is at least in part responsible for the present opposition to the use of the dilator and curette by a few men in the profession. Whatever is worth doing at all is worth doing well. Thorough work and clean work is possible only when a patient is passive from the influence of an anæsthetic. Hence I believe that all attempts at minor surgical operations on the pelvic organs in the office should be condemned.

The routine employment of applications to the endometrium for the cure of endometritis is another method of treatment which should be avoided. The experience of Emmet, Thomas, and Goodell (not to mention others), has demonstrated that this method of treatment is unsatisfactory, and that under certain conditions it is dangerous. When the uterine appendages are inflamed, and especially when the tubes contain pus, all manipulations of the uterus are liable to induce peritonitis, and hence are contra-indicated. These facts have been demonstrated so conclusively by the experience of the past twenty years, that the same old blunders should not be made in the future. In my own hands application to the entire endometrium are made only after careful dilatation and curetting of the uterus, done under anæsthesia and with full antisepsis, and in the rare cases in which the uterine canal is very patulous. My own experience is similar to that of Goodell, Emmet, and others, that the less one uses intra-uterine applications the more he believes that they are harmful rather than useful. I would not go so far as Emmet and condemn intra-uterine applications absolutely, but I believe that their field of usefulness is a very restricted one.

The employment of pessaries does not cause as much evil as formerly because the limitations of the use of the pessary are better understood. The teachings of the school of Hodge concerning the nature of the displacements of the uterus and their treatment by means of the pessary made a deep impression upon American medicine, and it is only now that much that was erroneous is being eliminated from current beliefs. Since Hodge's day practically all that we know concerning injuries of the pelvic floor and pelvic inflammation has been discovered; and theories concerning the sustaining forces of the uterus, the action of the intra-abdominal pressure, and the mode of

action of the pessary have been profoundly altered, especially through the labors of Schultz.

The mistake should be avoided of regarding a retro- or other "displacement of the uterus with adhesions" (according to the old nomenclature) as a disease of the uterus, and especially the greater mistake of treating such a case with a pessary. The disease in such cases is to be sought in the appendages.

With the rarest exceptions the use of pessaries should be limited to cases of retro-displacement or descent of the uterus, in which there has been no peritonitis and no laceration of the pelvic floor. If in such cases the displacement is first corrected and then a properly fitting Smith-Hodge, Emmet, or Thomas pessary is inserted no harm will result, and a cure will often be effected if the patient is carefully watched and the pessary kept clean.

Evil results, which should be avoided, follow the use of the pessary, in proper cases, when it is introduced without the previous reduction of the displacement; and especially when the pessary is inserted against inflamed and tender ovaries and Fallopian tubes.

When the theory is abandoned, that the pessary is a lever which holds up and tilts forward the uterus, and instead the theory is adopted that the pessary acts by pushing the vault of the vagina toward the sacrum, and hence pulling the cervix backward, and that the fundus is kept forward by intra-abdominal pressure, this useful instrument practically will cease to do harm because it will no longer be used in cases of "fixed uteri" and in cases of unreduced displacements.

The routine use of the sound as an instrument of diagnosis is another practice which should be avoided because of the danger of carrying infection into the uterine cavity, and the risk of unwittingly inducing abortion, and because a diagnosis can be made more accurately by the bimanual method without the slightest risk to the patient.

I shall now briefly present certain views concerning the positive side of office practice.

Unquestionably in gynecology, as in the whole field of medicine, successful treatment rests on accurate diagnosis, hence the necessity of carefully studying each case, not only as to the condition of the pelvic organs, but as to the state of the general health. The observing gynecologist early realizes the interdependency of diseases of the sexual and of the other systems of the body. Especially is this true of functional conditions, including the vascular supply of

the pelvis. Many women complain of symptoms referable to the sexual organs which are due to pelvic congestion, in turn due to a feebly acting heart, or to a sluggish portal circulation, or to lack of use of the muscles of the body. Just as these conditions predispose to hemorrhoids, or increase the size of hemorrhoids already present, so do they predispose to pelvic hyperæsthesia, and greatly increase the symptoms of any morbid condition present in the pelvis.

Likewise the influence of morbid states of the nervous system, especially the conditions known as hysteria and neurasthenia, upon the symptom-complex of pelvic disease is most marked. And the same is true of malnutrition and anæmia.

Whether a given pain is due to gross disease in the pelvis, or is due to hyperæsthesia of the pelvic nerves induced by pelvic congestion, or whether it is a manifestation of hysteria or of neurasthenia, or is a neuralgia due to anæmia and malnutrition is a problem always intricate, and at times difficult of solution.

These considerations should never be lost sight of in studying the problems of pelvic disease; and I feel certain that a full appreciation of them is of the greatest importance in pointing the way to successful treatment.

Successful management of pelvic disease means very much more than the use of local treatment. Broadly speaking, I believe that fully as much, if not more, can be accomplished for women suffering with pelvic disease by hygienic management and general medication as by local treatment. Of course, this statement does not include cases requiring operation. Frequently what is most required is to regulate the bowels, to correct digestive disturbances, to give iron and arsenic for anæmia, to advise rest and recreation for the overworked, and to infuse hope into the despondent and hypochondriacal.

In my own work I feel that I have no more important ends to accomplish than to combat malnutrition, anæmia, and constipation, and to induce overburdened women to live more in the open air, and to secure more hours for relaxation and amusements.

In the actual diagnosis of pelvic disease, by physical examination of the parts, touch and the bimanual examination are the safest guides. No instrument will reveal so much as the educated sentient fingers. Indeed, the bimanual examination is of more value than all other methods of diagnosis combined. In no other way can the entire pelvis be explored, and the condition of the uterus and its appendages be known. Vision and instrumental aids to diagnosis

are of value, but their usefulness is restricted to cases of vulvar, vaginal, and cervical disease.

On making the bimanual examination I have found it most useful to employ two fingers in the vagina instead of one. At least half an inch is gained in this way. A distinct advantage is gained also by using the fingers of the left hand for exploring the left side of the pelvis, and of the right hand for the right side of the pelvis.

If the confidence of the patient is gained, and her fear of being hurt is removed, and if she is instructed to breathe regularly during the examination, in almost every case the entire pelvis can be explored. At times, when the vagino-abdominal method of examination is unsatisfactory, the recto-abdominal examination clears up the diagnosis.

The speculum is of value as an aid to diagnosis only in cases of vaginal and cervical disease. Its chief importance is as a canula to facilitate the making of applications to the cervix and vagina. Hence one should be selected which can be used without causing pain. This indication is met by the Sims's speculum, but its use involves the necessity of an assistant, and in addition the expenditure of unnecessary time, hence it should be used only in special cases when it is desirable to study vaginal or cervical lesions, or when there is great pelvic tenderness, or when there is a cancer of the cervix, which might be abraded by the bivalve speculum with the induction of hemorrhage. I have found the virgin size of the Nott trivalve speculum the most satisfactory for general use.

In making applications to the cervix and to the vault of the vagina, I have found a whalebone applicator, made for me by Lentz & Sons, to be of such convenience that I show it here. It is a tapering rod of whalebone ten inches in length, flattened at the smaller end. A layer of cotton wrapped upon the applicator is sufficiently secure for use in making applications to the vagina and cervix, and yet can be removed easily and quickly by grasping it with forceps. In this way it is possible to avoid staining the fingers, and the loss of time necessary in removing the medicated cotton from the ordinary aluminium applicator. Another advantage is that its size prevents its introduction into the undilated uterine cavity.

In conclusion, I will urge again that it is wise in office practice to avoid all operative procedures and all methods of treatment which

are painful, because of the dangers of inducing inflammation and septicæmia. The office treatment of the diseases of women should be limited to prescribing the hygienic, dietetic, and medicinal remedies appropriate to each case, and to the employment of vaginal and cervical applications, the reposition of displaced organs, the careful use of massage, and the fitting of pessaries.

DISCUSSION.

Dr. Barton Cooke Hirst: I have very little to add to this comprehensive paper. I quite agree with the writer that the treatment of gynecological cases in the office should be restricted as much as possible. I early learned this by an experience with one or two distressing cases in which I was obliged to remain in the office long after office hours to watch them.

There are one or two little points which might be enlarged upon. One is the rectal examination. At the first examination of a patient I resort to it in every case. I have found in quite a number of instances that I have been able to detect an abnormal condition of the ovary which was wholly inappreciable through the vagina. The rectal examination, if sometimes of no use, does no harm and entails no risk.

There is another point that I think might have been touched upon. There is a danger in this kind of practice which should not be lost sight of, and the true nature of which should be exploited wherever possible. I refer to the disagreeable consequences arising from the examination of erotic females and of designing women. This is not a pleasant subject to dwell upon, but it is a constant danger, and harm of a serious kind may come to the practitioner if it is ignored. I think, therefore, that the possibility of erotic excitement, and the possibility of blackmail in office gynecology, should be referred to, in order to warn the younger men, and so far as we can to give the laity an idea of the true nature of the majority of these cases. There is a well-known case in this city of an unfortunate dentist who was sentenced to jail on this account, and yet I have been told that he undoubtedly was innocent. The same experience may occur to anyone.

Dr. William H. Parish: The paper which has been presented is a very safe and sound one. The main point submitted in it is that we do harm to our patients in our office work. I am confident that too much is attempted in the office, and can recall a number of instances in which patients were made worse by the treatment there instituted. It is a wise procedure on the part of Dr. Noble to bring this subject before us, in order that the experiences here related may be of service to others. The dangers of sepsis, now fully appreciated, were at one time not recognized by the surgeon and gynecologist. At that time it was quite the universal practice to introduce a sound into the uterus of every woman who presented herself for examination, unless there was strong reason to believe that pregnancy existed. I do not doubt that much trouble is still caused by the sound or other instrument being carried into the uterus—measures to avoid sepsis not being observed.

I practically agree with Dr. Noble in all the detailed statements made in his paper. I have long given up the practice of gradual dilatation in the office. In some cases it is injurious, and in many it is of no service. If the operation is needed, it should be done at the patient's home, or in a hospital, with proper precautions. The same remarks are true as to the use of the curette.

With reference to the use of intra-uterine applications in the treatment of endometritis, although early brought up to the belief that these were essential in almost every case of endometrial inflammation, I now think that they should be reserved for cases that are exceedingly obstinate, or where there is septic material in the uterus. These applications should always be made at the house of the patient or in the hospital.

The use of pessaries has largely diminished, but one who sees these cases will be surprised to find how many pessaries are used in cases where there is no indication for them, and where they do no good, and even do great harm. They are used where there are contra-indications—such as adherent uterus or adherent ovary. I have not much faith in pessaries, limiting their use to cases of simple falling of the uterus, with or without retro-displacement.

So far as erotic cases are concerned, I think that they are exceptional; but it is well that their presence should be recognized. In a number of years of practice, I have not come across a case that gave me any concern. I know of two or three physicians who would not examine a woman except in the presence of a third person, and in one case except when another member of the family is present.

Dr. William E. Ashton: I agree with Dr. Noble that a great deal of harm has been done and will be done through office practice. If we are to do anything in the office in the way of gynecological work, we should approach it with the same aseptic precautions as though we were opening the abdominal cavity. The experience of the past and the present certainly shows that tinkering in a septic way with the uterine cavity is responsible for many cases of tubal and ovarian disease.

I believe that pessaries have a very limited use. It matters not whether the pessary acts by pressure upon the posterior wall of the uterus or by elongating the posterior wall of the vagina and bringing the cervix backward, as in either case damage is done to the utero-sacral ligaments, which are the chief supports of the uterus. These ligaments are elongated, and as a result we have an increase of the trouble when the pessary is removed. The use of the pessary should be limited to those cases where, for a short period of time, we wish to shore up the uterus, and to cases where the uterus is but slightly prolapsed and retroflexed. The pessary is especially useful in pregnancy when there is retro-displacement and prolapse. Its use in these cases for the first four months prevents the possibility of incarceration.

Dr. Noble has brought out in a forcible way the importance of constitutional treatment in the diseases of women. The time has passed when we expect much from local treatment. Unless we recognize the necessity for constitutional treatment we shall get bad results.

Dr. Joseph Hoffman: The remarks of Dr. Noble in regard to uterine massage and those of Dr. Hirst can well be put alongside of one another in a critical way. Dr. Noble speaks of uterine massage being allowable in the

office. Dr. Hirst says that in certain erotic females there is danger in office treatment. If there is anything that is apt to bring on these dangers, it is the abominable practice of uterine massage. I think that it would be no more reprehensible to have a male attendant in the women's division of the Turkish bath, than for a man to practise uterine massage. I think that it is disreputable, foul, and wrong. I say that from the moral side of the question. Any trouble in the uterus that needs to be broken up by massage is a trouble that is so far gone that it is not safe to break it up. It is not safe to break up adhesions in the pelvis by this means. When we have our fingers on these adhesions we know how difficult it is to break them, and they may even require the use of the scissors. Uterine massage is out of place both morally and physically.

A word in reference to pessaries. In this reaction against the use of pessaries we are perhaps going too far, and may forget that they are sometimes of use. I can put my fingers on three cases of acute retroversion occurring in the past few weeks, where great benefit has followed the use of the pessary. One patient was bleeding twice a month, another was incapacitated from work, and the third was almost unable to work. There is as much care needed in the fitting of a pessary as in the fitting of a stocking or a shoe, and the pessary should be adjusted for each particular case.

I disagree with Dr. Ashton in regard to the use of the pessary in pregnancy. If I wanted the woman to miscarry, I should use a pessary, for I believe that the irritation of the pessary would induce miscarriage. Where the uterus is retroflexed, the best plan is to restore it mechanically, and then allow the patient to remain in bed as long as necessary.

Dr. G. Betton Massey: From a philosophical point of view, the sense of the paper is that gynecologists are unnecessary. If these diseases of women are to be cured by hygienic and constitutional measures, why cannot the general practitioner do all that is necessary? In my experience, the cases that come to me outside of dispensary practice have had that tried. We are to be congratulated that the time has at last come, in minor surgical gynecology, when the gynecologists themselves are willing to acknowledge bad results. If they would but sit down quietly and apply the same serious judgment to their major gynecology, they would reach somewhat similar results. For the life of me I cannot understand why it is unsafe to pass an aseptic instrument into the cavity of the uterus, and yet it is safe to perform abdominal section in order to make a diagnosis. It is the abdominal sectionists who are willing to acknowledge the noxiousness of local treatment. I think that one of the explanations of this anomaly is attributable to the position taken by Philadelphia gynecic surgeons, wherein they differ from gynecic surgeons in other cities in failing to appreciate the value of electrical treatment in the office. If they used electricity in these cases they would find that the patients are better able to go home than to come to the office, and their exceedingly agnostic position would be modified materially.

Dr. Noble: I consider the rectal examination as a most valuable expedient. In the paper, which is a running commentary on many points, it was not possible to go much into detail. I stated, however, that if the bimanual examination by the vagina was not satisfactory, the rectal examination should be resorted to.

As to the reason that it is not wise to put a sound into the uterus, pathologists have taught us that the vagina constantly contains germs, and that the cervix as high as the internal os also contains germs, but that for some reason the internal os offers a barrier to the further ingress of germs, so that the endometrium is protected against invasion. If we pass an aseptic instrument through the cervical canal, it may carry germs into the uterus and set up inflammatory trouble. In my own hands the sound is used principally to reposit the uterus in a definite class of cases. Occasionally the uterus is so flexible that the ordinary bimanual method of Schultz will not answer. If the patient is put in Sims's position, the uterus usually can be replaced, but occasionally the sound will be required. I always clean the cervix as well as possible, and see that there is no disease of the appendages.

My reference to uterine massage in the paper consisted of this phrase—"the careful use of massage." I think that the field of usefulness of massage is extremely limited. So-called cases of displacement of the uterus with adhesions are cases of adherent appendages which require removal, particularly if the tubes form retention cysts. Occasionally we find cases in which there has been peritonitis and the appendages are adherent, but from the symptoms and the physical examination there is no reason to believe that the tubes are occluded and distended. The adhesions may be light, and there may be retro-displacement of the uterus. In a few such cases I have, by careful packing of the vagina for a long time, been able to overcome the retro-displacement and give the patient much relief. I am very suspicious of active massage, and certainly would not put myself in the position of recommending it in inflammatory conditions of the uterine appendages. It is only to be used in these rare cases. I have nothing to say on the immorality of the measure.

I agree with Dr. Ashton that if we have a retroflexed pregnant uterus, and if by manipulation it is possible to reduce it, it is a good practice to introduce a well-fitting pessary. At the same time I think that is well to keep the patient quiet for a reasonable length of time. I have not infrequently used a pessary in these cases, and have not had abortion follow.

My paper was not a plea for the existence of gynecologists, but it was upon some points in office practice; therefore I do not feel called upon to reply to Dr. Massey's criticism. Dr. Massey remarked that if gynecologists would use electricity, more patients would go home in a better condition than when they came to the office. But even he has detailed a case to-night in which the patient was so sick after leaving the office that she required the services of a physician, and was unable to return to the office, but had to go to bed to have the treatment applied.